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## Guest editorial

# Medicalised erections on demand?

Sir Douglas Black *Consulting Editor, Journal of Medical Ethics*

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Some time ago, I was surprised to be asked for an opinion on the use of sildenafil citrate (Viagra) in the treatment of impotence. Maybe the request related to my chairmanship some years ago of a working party on *Inequalities in Health*.<sup>1</sup> I am no expert on sexual medicine, but I share the general understanding that impotence is a failure to achieve a penile erection when required or desired. It is not to be confused with male sterility, for which we already possess circumventive measures, which may however be ineffective, cumbersome, and - like Viagra - costly.

This problem, like any other question of medical innovation, has medical, economic, and ethical aspects; and I very much agree with the view expressed at the 1998 annual representative meeting (ARM) of the British Medical Association (BMA), that all such innovations need careful consideration before being made generally available. But of course, "careful consideration" conceals unanswered questions, perhaps the most important being, consideration by whom? and using which criteria? Before expressing a view, let me first outline some of the factors which any consideration of this problem must take into account.

**Medically**, impotence, like cancer, is far from being a single disease or condition. To follow the crude distinction between organic and psychological disorders, so often in practice mixed as psychosomatic diseases, organic causes include local structural abnormalities, insufficiency of male hormone, diabetic and other neuropathies, and the side effects of medication. Psychological causes are probably responsible for many more cases of impotence than organic causes; and equally they cannot just be lumped together as loss of libido; they call for psychological analysis and counselling. These are deep waters; and I venture to make the politically incorrect suggestion that it might be a good idea to see a doctor before just buying something over the counter.

**Economically**, like any other medication the use of Viagra carries a cost. This is not trivial, and must fall either on the individual or on the community. Making the individual pay is in

accord with market libertarianism; but happily we seem now to be slowly emerging from the purest forms of that heresy which we enjoyed in the eighties. Moreover, distributive justice frowns on limiting a possible benefit to those who can afford it. The alternative in this country is to lay the burden on the National Health Service (NHS), whose troubles are many but do not include the embarrassment of having too much in the way of resources. But it must be recognised that such a measure carries the opportunity cost of diverting resources from other types of expenditure.

**Ethically**, one must start from the recognition that impotence in its various forms is a cause of great misery, to individual sufferers, to their partners, and ultimately to society. However, that does not automatically call for a rush to a form of treatment which is still largely untried at the population level, and which may then be discovered to have side effects so far unrecognised, in addition to the already recognised risk of heart attacks in the elderly.

There may also be undisclosed conflicts of interest, commercial and political - pharmaceutical companies like to be profitable, and politicians like to give people what they want, which is not always what they actually need. In an ideal world, actual need and perceived need would be identical, leading naturally to appropriate demand, which would then be met by fully resourced supply. In the world in which we live, the situation is somewhat different. In society generally, market forces have created a culture (JB Priestley's "Admass") in which advertisement stimulates demand, not necessarily based on actual need. People who worry about their health (and who does not at times?) are not cloistered from similar commercial pressures, as witnessed by the massive health shop industry, some of whose wares can scarcely be the answer to actual need. On the other hand, screening programmes commonly reveal undetected needs, which if treatable or correctable can be the basis for proper demand. I suggest that even if resources were unlimited, which they certainly are not, the mere existence of a demand, even a clamant one, is not

a sufficient reason for making a new provision. (I have here to confess the bias of having been brought up in the austerity of a Scotch manse, where one of the lessons was, "I want" doesn't necessarily get).

### The way ahead

The availability of Viagra in a number of countries was reviewed in the *British Medical Journal*.<sup>2</sup> It would not be unfair to describe the situation as confused; but this may reflect the difficulty of the relevant decisions rather than intrinsic incapacity of those responsible for making them. In the USA, where the medicament has been available since April, the federal US Department of Health and Human Services has stated that if Viagra is "medically necessary", then Medicaid should pay for it: but many of the state-run Medicaid programs are refusing to do so; insurers and health maintenance organisations vary in what they do; and in the upshot around 60 per cent of sildenafil prescriptions are paid for privately - such are the benefits of the system which the UK aspired to copy in the 1990 reforms, from which it is now beating a slow retreat. In several continental European countries, patients generally have to pay the whole or part of the cost of sildenafil; it was still not available in Spain, and Italians were travelling to Switzerland or San Merino in pursuit of it. France has decided not to reimburse the cost of the actual medicament; but the relevant ministry remains concerned about the cost of the related medical consultations which are reimbursed in part. In Israel, sildenafil is available on prescription, but is not paid for by the "financially pressed national health insurance system".

There is clearly no international model to which the UK could look with confidence to set its own house in order, unless of course it travels the road of *laissez faire*, that those who want it pay for it. That should be a last resort, and the government has rightly turned away from it, while sensibly recognising that another form of *laissez faire*, that of funding any and every demand, is economically unacceptable. The advice of the Standing Medical Advisory Committee is that doctors should not prescribe sildenafil for erectile dysfunction other than "in exceptional circumstances". The same *British Medical Journal* article reports<sup>2</sup> what seems a curious arrangement, that doctors may not prescribe privately for one of their own patients, but may do so for a patient from another practice. There is still a good deal of tidying up to be done; and I doubt if it will be possible, or indeed should be, to satisfy the BMA's reported plea to the health authorities "to make a decision about the

availability or otherwise of sildenafil under the NHS as quickly as possible".<sup>2</sup> Whatever urgency there may be in this problem is political rather than clinical; and the careful consideration advocated at the BMA's 1998 ARM calls for a more measured approach. My reasons for saying so are that this is a problem which needs an input from several disciplines, including but not limited to the health professions; and that the decisions to be taken will not only be difficult in themselves, but will have implications for the handling of expensive innovations in the future. In what used to be called "speed and accuracy tests" for typing, accuracy was always to be preferred to speed. Similarly in this case.

One important conflict which lies outside the medical sphere (some conflicts still do), but on which a decision will have to be made is that between expressed demand and objective need. Societal opinion, and especially politically correct opinion, is strongly set in favour of accepting almost any demand, based on the autonomy of the demanding person; and against professional assessment of needs, which is seen as paternalistic, and even as a conspiracy against the people. Gone, and unlamented, are the days when all decisions relating to sildenafil would have been made collectively by groups of doctors, and interpreted to individuals by trusted practitioners. But it would be no great advantage if groups of doctors were simply to be replaced by groups of lawyers or of managers. The major decisions have ultimately to be taken by our elected representatives in parliament, acting on advice but not constrained by it.

They must consider the balance of clinical benefits and risks on best available evidence; a workable definition of what might constitute "exceptional circumstances" in which the health-related benefits justified the use of an expensive drug; the appropriate certifying agents of such circumstances; the likely financial cost to the NHS; the additional demands on the time and skills of health professionals; and even, as political professionals themselves, the effect of the decisions on the electorate. Their advice from health professionals can cover only a part of this complex problem; it will have to be complemented by the views of economists, administrators, sociologists, lawyers, and even perhaps psephologists. For such a task, it might even be necessary to set up a working group with multiprofessional and also lay representation. Such groups may at times have influence, though they may have to wait some time to see it.

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## References

1 DHSS. *Inequalities in health: report of a research working group*. Chaired by Sir Douglas Black. London: DHSS, 1980. (Copies of this are now hard to obtain, but an abridged version

forms part of: Townsend P, Davidson N, Whitehead M, eds. *Inequalities in health* [2nd ed]. Harmondsworth: Penguin, 1992.

2 Beecham L *et al*. Viagra falls: the debate over rationing continues. *British Medical Journal* 1998; 317: 836-8.

## News and notes

### Announcing the April special issue...

### Ethics and the new genetics

The April issue of the *Journal of Medical Ethics* will be a double issue of about 25 papers dedicated to the subject of ethics and the new genetics. The guest editors are Professor Bob Williamson and Associate Professor Julian Savulescu of the Murdoch Institute for Research into Birth Defects, Melbourne, Australia.

This special issue will be of interest and benefit to a wide cross section of clinical and non-clinical professionals at a time of rapid and profound change in this area.

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*John Harris and Justine Burley*
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*Daniel Wikler*

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*Julian Savulescu*

- Preimplantation genetic diagnosis and the "new" eugenics

*David King*

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## News and notes

### Change of address

The Editor of the journal wishes to alert readers and contributors to the journal's new address: *Journal of Medical Ethics*, 36 West Towers, Pinner, Middlesex HA5 IUA.